nationalgrid

Notice of Life-Sustaining Equipment

Account Number: _____

Customer Name: _____

Service Address: _____

City/Town, Zip: _____

Telephone Number: _____

It is important that the account information listed above is correct. ***Please Print****.*

Do you have life-sustaining equipment in your home?

☐ No. Life-sustaining equipment is no longer in my home. Please remove my name from your list.

Signature: ..... Date: .....

☐ Yes. The following life-sustaining equipment is in my home:

- ☐ Tank-type Respirator (Iron Lung)
- ☐ Curaisse-type Respirator (Chest)
- ☐ Rocking Bed
- ☐ Electrically operated Respirator
- ☐ Suction Machine (Pump)
- ☐ Hemodialysis Equipment (Kidney Machine)
- ☐ Intermittent Positive Pressure Respirator
- ☐ Special Air Conditioner *(Please explain why you need this)*
- ☐ Heart Rate Monitor
- ☐ PD APNEA Monitor
- ☐ Diaphragm Stimulator
- ☐ Oxygen Concentrator
- ☐ Medical Pump
- ☐ Press Respirator
- ☐ CPM Drum ventilator

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☐ Other types of life-sustaining equipment or medical condition *(Please be specific)*

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If you would like to authorize someone that we may discuss your account with other than yourself, please provide that party's information below.

Third Party Name: .....

Third Party Address: .....

Third Party City, State, Zip: .....

Third Party Telephone: .....